FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
JUNE 7, 2001

Intermediaries

Medicare Integrity Program

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FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Medical Review (Intermediary)

The Medical Review (MR) Budget and Performance Requirements (BPRs) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). Program Integrity's primary principle is to pay claims correctly. In order to meet this goal intermediaries must ensure that they pay the right amount for covered services rendered to eligible beneficiaries by legitimate providers. HCFA follows four parallel strategies that assist us in meeting this goal:

- preventing inappropriate payments through effective enrollment and through education of providers and beneficiaries;
- early detection through, for example, medical review and post-pay data analysis;
- close coordination with our partners, including contractors and law enforcement agencies; and
- fair and firm enforcement policies in accordance with the principles of Progressive Corrective Action (PCA).

Medical Review's primary mission is to reduce the claims payment error rate. Medical Review staff have a variety of tools to use in support of their mission. Primarily medical review reduces the error rate by identifying patterns of inappropriate billing and educating providers concerning appropriate Medicare billing.

For FY 2002, HCFA will be funding each contractor's level of effort used to reduce the claims payment error rate. Each contractor will be given a specified maximum budget for MR. Based on this budget the contractor is asked to develop a unique MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the error rate. Contractors must identify the appropriate budget and workload for each CAFM II code within the constraints of their budgets. Contractors must describe how their MR strategy will support an error rate reduction. Since a significant MR activity is based in remedial provider education, contractors may need to supplement the MIP PET budget with MR funds. All MR education activities are funded through MIP PET. Contractors with multiple medical review sites must create a separate MR strategy and budget for each site. Contractors must provide their MR strategy when submitting their budget request. Additionally, contractors with multiple MR sites must separately track workload and funding for each site and report this data in the Remarks section of CAFMII for each Activity Code. Also, contractors must submit an updated Quality Improvement Program plan to assess and monitor their MR strategy with their budget request. Negotiations with the RO budget and MR staff will concern the strategy and the individual elements of the strategy.

In addition to satisfying all requirements contained in the Medical Review (MR) Budget and Performance Requirement (BPR), intermediaries must carry out all medical review activities identified in the Program Integrity Manual (PIM) and all relevant medical review Program Memoranda.

Discontinued MR Activities

In FY 2002, the Health Care Financing Administration (HCFA) will no longer fund the following activities:

- ***CAFM II reporting for Activity Code 21004 - non-CMR postpayment claims review***
- ***CAFM II reporting for Activity Code 21005 - on-site CMRs***
- ***CAFM II reporting for Activity Code 21006 - in-house CMRs***
- ***CAFM II reporting for Activity Code 21009 – law enforcement—If the MR unit is asked to do review as part of a fraud case development, the costs incurred should be charged to the Benefit Integrity (BI) line CAFM II code 23007. Because the main goal of medical review is to change provider billing behavior through claims review and education, any BI initiated review activity that does not allow for provider education or feedback must be charged to the BI unit.***

Continuing MR Activities

In FY 2002, the following MR activities are to be continued from FY 2001, with new goals/requirements described:

- Submit a MR Strategy to the Regional Office and to the Central Office at MROperations@cms.hhs.gov with your budget (These requirements will also be manualized through CR 1485 by the start of FY 2002). Each contractor will be given a specified budget for MR. Based on this budget the contractor is asked to develop a unique MR strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the error rate. Under the Government Performance and Results Act (GPRA), HCFA has a FY 2002 goal to reduce the Medicare fee for service paid claims error rate to 5 percent. Contractors are not requested to establish a baseline error rate or calculate a contractor specific error rate to be judged against the GPRA goal. The Comprehensive Error Rate Testing Program will eventually provide the baseline measurements.

When submitting the MR Strategy. The contractor shall:

- Complete the following chart:

CAFM II Activity Code	DOLLARS	PROJECTED WORKLOAD		
		Workload 1	Workload 2	Workload 3
21001				
21002				
21003				
21007				
21008				
21010				
21030				
21031				
21032				
21100				

- Identify, by job title, the number of FTEs for each CAFM II activity code crosswalked to an employee list;

- Identify the intended areas for focusing the contractors MR resources;

- Identify the processes that the contractor shall use to monitor spending in each MR activity code to ensure that spending is consistent with the allocated budget. This shall include the processes the contractor shall undertake to revise or amend the plan, when spending is over or under the budget allocation;

- Identify the process that assures the accuracy and the consistency of reporting workload for each CAFM II code and assesses the proper allocation of FTE/hrs that are required for each activity;

- Identify the data analysis process the contractor will employ in carrying out the MR program; and

- Identify the provider educational processes the contractor will employ throughout the MR program.

- Contractors may perform automated, routine, and complex prepayment review and all types of post-payment reviews. Contractors should determine the appropriate amount of review to be performed for each CAFM II code within the constraints of their budget. Consideration should be provided for the cost effectiveness of each tool, as well as the appropriateness of each tool for resolving identified problems in achieving the overall goal of reducing the claims payment error rate.

- In order to prevent "bunching," intermediaries should complete 20-30% of their workload for each MR activity code per quarter.

- Only in those instances where reviews cannot be automated and no clinician review is indicated shall the intermediary conduct routine manual reviews.

- Intermediaries are now required to employ at least a part-time CMD.

- Submit an updated Quality Improvement Program plan with your MR strategy and budget request.

- Semi-annual submission of the Quality Improvement Program report to be entitled "MR QI Program". The report is due to both the RO and CO (at MROpertations@cms.hhs.gov) no later than 30 days after the close of the 2nd and 4th quarters. (*See Attachment A – Deliverables).* The specific QI Program report requirements are listed below (These requirements will also be manualized through CR 1485 by the start of FY 2002.):

Contractors must assure the implementation of an effective Quality Improvement Program (QIP). The QIP goals are to assure that the decisions are accurate, consistent and the Medical Review Strategy is being implemented efficiently and effectively. The contractor is responsible for identifying problems or potential problems with each QI process. In response to problems or potential problems identified, a contractor must formulate an intervention to address the problem/potential problem and evaluate the impact/effectiveness of the intervention. In FY 2000, the top five overall problems identified through the Contractor Performance Evaluation process were workload management, effective data analysis, edit development and evaluation of edit effectiveness, and accurate review decisions. As such, contractors, in formulating their QI Programs, should give special attention to these five areas. At a minimum, contractor's MR QI Program must:

- Establish Quality Improvement coordinators within the organization structure.
- Assure that all QI processes are written and catalogued together in a single manual.
- Include oversight of policy development.
- Assure accurate, consistent, and defensible decision-making by the MR staff, including employing physician participation in determining the accuracy of medical review decisions and regularly testing and improving inter-reviewer reliability.
- Include oversight of the data analysis process to ensure the contractor uses a variety of local and national data sources. The QIP should identify potential aberrant patterns with appropriate translation of findings into a prioritized review strategy. The QIP should consider PCA, MR, appeals, and reversal findings and trends when considering changes in methodologies and procedures.
- Establish written methods for conducting objective assessment of all MR functions.
- Validate the appropriateness of the MR process.
- Assure that the MR system has the capacity to draw on special expertise when necessary for conducting medical review/claim determinations.
- Assure the internal education efforts are effective and efficient.
- Assure provider education efforts are effective and efficient. (Remedial provider education is a MIP PET activity.)
- Demonstrate proficient management practices, with written policies and procedures that are up-to-date to address identified problems and appropriate remedial action. One way the contractors can assure proficient management procedures is to become ISO 9000 certified[1] or to undergo a third party validation process.
- Include a process that assures the accuracy and the consistency of reporting workload for each CAFM II code and assess the proper allocation of FTE/hrs that are required for each activity.

New MR Activities

In FY 2002, intermediaries must begin performing the following activities:

- Reporting for Activity Code 21030 – Routine Manual Postpay Review
- Reporting for Activity Code 21031 – Complex Manual Provider Specific Postpay Reviews
- Reporting for Activity Code 21032 – Complex Manual Service Specific Postpay Review
- Reporting for Activity Code 21100 - Program Safeguard Contractor (PSC) Support Services- Contractors should begin tracking and recording costs associated with providing support services to Program Safeguard Contractors (PSCs) (e.g. pulling records, xeroxing, and record review). The total amount spent providing support services to all PSCs should be recorded under Activity Code 21100. In addition, contractors must report the cost of providing support services to the specific PSCs listed below under the appropriate Miscellaneous Code(s) (e.g. any support work done for the WIC is to be reported under Miscellaneous Code 21100/06). *(Additional information in forthcoming PM).*

(1) For more information concerning ISO 9000 certification, on the World Wide Web go to www.ASQ.org, or call 1-800-248-1946.

Miscellaneous Codes for Activity Code 21100:

- 21100/01 – Y2K PSC (Y2K)
- 21100/02 – Provider Education (Provider Education)
- 21100/03 – Review of Providers Subject to Corporate Integrity Agreements (CIA)
- 21100/04 – Statistical Analysis Center (SAC)
- 21100/05 – Comprehensive Error Rate Testing Program (CERT)
- 21100/06 – Western Integrity Center (WIC)
- 21100/07 – Therapy Services PSC (TRP)

- Contractors must complete prepay and postpay complex reviews within 60 days of receipt of medical records (These requirements will also be manualized through CR 1485 by the start of FY 2002).

Quantifiable MR Activities

Automated Review (Activity Code 21001)

Maximize automated review and whenever possible, implement national coverage policies (NCPs) and/or local medical review policies (LMRPs) through system edits.

Report the costs associated with automated review including personnel to install and activate supplemental edit software in Activity Code 21001. In the workload section of CAFMII, Activity Code 21001, intermediaries should report the number of claims denied in whole or in part in Workload 1. To the extent the intermediary can report claims subjected to automated review, this number should be recorded in Workload 2. To the extent the intermediary can report providers subjected to automated review, this number should be reported in Workload 3. *(PIM Ch. 3 § 5.1; PIM Ch. 11)*

Routine Manual Prepay Reviews (Activity Code 21002)

Report all costs associated with routine manual prepay reviews in Activity Code 21002. In the workload section of CAFMII, Activity Code 21002, report the number of claims reviewed in Workload 1. Intermediaries should report number of claims denied in whole or in part in Workload 2. To the extent the intermediary can report providers subjected to routine review, they should report this number in Workload 3. *(PIM Ch. 3 § 5.1; PIM Ch. 11)*

Complex Manual Prepay Reviews (Activity Code 21003)

Report all costs associated with complex manual prepay reviews in Activity Code 21003. In the workload section of CAFMII, Activity Code 21003, report the number of claims reviewed in Workload 1. Report the number of claims denied in whole or in part in Workload 2. To the extent the intermediary can report providers subjected to complex review, they should report this number as Workload 3. *(PIM Ch. 11)*

Data Analysis Activities (Activity Code 21007)

In addition to the activities described in the Program Integrity Manual intermediaries must accommodate the following data analysis activities:

- Perform on-going data analysis.

- Use data analysis to develop and implement system edits and to determine the need for policy development.

Report all costs associated with data analysis activities in CAFM II Activity Code 21007 **except** for data analysis associated with benefit integrity and law enforcement support. There is no final claims workload to be reported for this activity. *(PIM Ch. 2)*

Policy Development Activities (Activity Code 21008)

Report all costs associated with LMRP activity and BIPA §522 activities in CAFM II Activity Code 21008. Report the number of policies that required notice and comment and became effective as Workload 1. Report the number of policies that were presented for notice and comment as Workload 2. Report the number of policies that were revised but did not require notice and comment as Workload 3. *(CR 1021 provides additional guidance and has an effective date of November 24, 2000; PIM Ch. 1 §§ 2, 6)*

Third Party Liability or Demand Bills (Activity Code 21010)

Report the costs associated with the medical review of third party liability and the medical review of demand bills in Activity Code 21010. In the workload section of CAFM II, Activity Code 21010, report the total number of claims reviewed, i.e., third party liability claims plus claims for demand bills, in Workload 1. Report the number of claims denied in whole or in part in Workload 2. Report demand bills (claims) in Workload 3. *(PIM Ch. 11)*

Postpayment Claim Review Activities (Activity Codes 21030, 21031, 21032)

Activity Code 21030 -- Routine manual postpayment claims review. Routine manual postpay review occurs when a provider or contractor has identified a systemic problem in the providers billing system that can be corrected only through the routine review process.

Activity Code 21031 -- Complex manual provider-specific postpayment claims review.
Complex manual, provider specific reviews include review of medical records and other pertinent clinical information associated with a specific provider claims.

Activity Code 21032 -- Complex manual service-specific postpayment claims review.
Complex manual, service specific review includes review of medical records and other pertinent clinical information associated with the provision of a specific item or service regardless of the provider(s) of the items or services.

Report all costs associated with the postpayment medical review of claims, e.g., sampling design and execution; claims examination, reviewing medical records and associated documentation; assessing overpayments; and contacting providers to notify them of overpayment assessment decisions.

Report all costs associated with routine manual postpayment claims review, complex manual provider specific postpayment claims review, and complex manual service specific postpayment claims review in Activity Codes 21030, 21031, 21032, respectively. In the workload section of each CAFM II code, report the total number of claims reviewed on a postpayment basis as Workload 1, report the total number of claims denied in whole or in part as Workload 2. To the extent the intermediary can report providers subjected to postpayment review, they should report this number as Workload 3.

Intermediaries must keep a record of their postpayment review workload using miscellaneous codes in CAFMII for the following information: the number of consent settlements offered (Miscellaneous Code 21031/01), the number of consent settlements accepted (Miscellaneous Code 21031/02), and the total number statistical samples for overpayment extrapolation (formerly statistically valid random samples (SVRS)) performed (Miscellaneous Code 21031/03). This information must be entered into CAFM in the miscellaneous field for CAFM II code 21031. *(PIM Ch. 3, §6; PIM Ch. 11)*

Other Activities

Intermediaries must work with any and all Program Safeguard Contractors (PSC), or other entities that contract with HCFA.

Attachment A

Medical ReviewDeliverables

Report	*Due date(s)*	*Submitted to*
MR Strategy Report (Note: Multiple MR sites are required to submit separate reports)	Submit with Budget Request	Regional Office MROperations@cms.hhs.gov (must be submitted via the VP of Government Operations)
MR Quality Improvement Program Plan	Submit with Budget Request	Regional Office MROperations@cms.hhs.gov (must be submitted via the VP of Government Operations)
MR Quality Improvement Program	May 1, 2002 November 1, 2002	Regional Office MROperations@cms.hhs.gov

Attachment B

SUMMARY OF MEDICAL REVIEW CAFM II ACTIVITY CODE DEFINITIONS FOR INTERIM EXPENDITURE REPORTS

ACTIVITY CODE	REVIEW TYPE	WORKLOAD 1	WORKLOAD 2	WORKLOAD 3
21001	Automated Reviews	Claims denials in whole or in part	Claims subjected to automated review	Number of Unique Providers
21002	Routine Manual Prepay Reviews	Claims reviewed	Claims denied in whole or in part	Number of Unique Providers
21003	Complex Manual Prepay Reviews	Claims reviewed	Claims denied in whole or in part	Number of Unique Providers
21004, 21005, 21006	**DELETED**	**DELETED**	**DELETED**	**DELETED**
21007	Data Analysis (Costs only)	N/A	N/A	N/A
21008	Policy Development	Number of policies requiring notice and comment that became effective during the month	Number of policies presented for notice And comment during the month	Number of policies revised that did not require notice and comment
21009	**DELETED**	**DELETED**	**DELETED**	**DELETED**
21010	Third Party Liability and Demand Bills	Claims reviewed	Claims denied in whole or in part	Claims associated with demand bills
21030	Routine Manual Postpay Reviews	Claims reviewed	Claims denied in whole or in part	Number of Unique Providers
21031	Complex Manual Provider Specific Postpay Reviews	Claims reviewed	Claims denied in whole or in part	Number of Unique Providers
21032	Complex Manual Service Specific Postpay Reviews	Claims reviewed	Claims denied in whole or in part	Number of Unique Providers

FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Medicare Secondary Payer (Intermediary)

THESE REQUIREMENTS STAND ALONE AND SUPERSEDE PRIOR YEARS BPRS

In past years, the BPRs provided the sole basis for contractor work priorities. The BPRs for FY 2002 will detail areas of focus in addition to ongoing MSP activities.

These BPRs presume funding for ongoing activities. In general, these MSP activities are described in the Medicare Intermediary Manual (MIM) sections 3400's, 3600's and 3899 as well as the specific Program Memorandums identified below.

PM's: AB-00-11 (CR#899), AB-01-24 (CR#1280), AB-00-27 (CR#1142), AB-00-107 (CR #1163), AB-01-25 (CR # 1558), AB-00-129 (CR #1460), CR#1244, AB-01-83 (CR#1538)

Note: *All memoranda referenced in FY 2001 BPRs will be incorporated in the manuals by October 1, 2001.*

MSP PRE-PAY ACTIVITIES - (ACTIVITY CODES 22001, 22005, and 22006)

The following MSP pre-pay activities are listed in order focus priority. Formal requirements and instructions are found for each activity in CR 1163, Transmittal AB-00-107, dated November 9, 2000, CR 1460, Transmittal AB-00-129, dated December 19, 2000, CR 1558, Transmittal AB-01-25, dated February 7, 2001, and MIM 3693 as outlined below.

1. Adding/Updating HCFA records timely and electronic requests and referrals for COB contractor update of HCFA records.
2. Electronic requests and referrals to the COB contractor for MSP and Claims issues.
3. Electronic requests and referrals to the COB contractor for liability, no-fault, and workers' compensation cases.
4. MSP hospital audits and reviews.
5. Electronic requests and referrals to the COB contractor for MSP record deletions (and/or for further investigation, if appropriate).

1. Adding/Updating HCFA Records Timely and Electronic Requests and Referrals for COB Contractor Update of HCFA Records (Activity Code 22001)

Instruction: CR 1163, Transmittal AB-00-107, dated November 9, 2000.

Note: *Adding "I" auxiliary records to CWF to process a claim for secondary payment should be reported for under Activity Code 22001.*

2. Electronic Requests and Referrals to the COB Contractor for MSP and Claims Issues (Activity Code 22001)

Instruction: CR 1163, Transmittal AB-00-107, dated November 9, 2000.

Note: *ECRS entries that are claims related should be reported under Activity Code 22001.*

3. Electronic Requests and Referrals to the COB Contractor for Liability, No-Fault, and Workers' Compensation Cases (Activity Code 22001)

Instruction: CR 1163, Transmittal AB-00-107, dated November 9, 2000 and CR 1558, Transmittal AB-01-25, dated February 7, 2001.

Note: *ECRS entries that are postpay activities should not be reported under Activity Code 22001.*

4. MSP Hospital Audits (Activity Code 22005)

Instruction: MIM 3693

Note: *This includes all on-site audits, such as hospital audits, and subsequent audit reports.*

5. Electronic Requests and Referrals to the COB Contractor for MSP Record deletions (and/or for further investigation, if appropriate). (Activity code 22001)

Instruction: CR 1163, Transmittal AB-00-107, dated November 9, 2000 and CR 1558, Transmittal AB-01-25, dated February 7, 2001.

Workload Definition--Code 22001

Prepayment claims workload is all activities on claims on which you take some MSP action before the claim is paid. This would also include ECRS access and transmission.

Note*: No workload or costs associated to initial claims entry should be charged to the MSP Activity Code 22001. Bill payment activities must be reported to the Program Management Activity Code 11001.*

MSP POST-PAY ACTIVITIES (ACTIVITY CODES 22002, 22003, 22004 and 22006)

The following MSP post-pay activities are areas of focus for FY 2002. ALL OF THESE ACTIVITIES ARE MANDATORY.

Funding should be requested for the following activities, which are listed in focus priority order:

1. Pursue recovery of identified primary mistaken payments as it relates to Liability, No-Fault, Workers Compensation, Data match and Non-Data match. This would include the issuance of the response letters. *(See narrative for clarification.)*
2. Continue the identification of MSP debt to be written off (CR #1280)
3. Continue the process of referring Debt Collection Improvement Act of 1996 (DCIA) classified debt activity. (CR#1538).
4. Implement the MSP Write-Off--currently not collectible (CNC) identification and reporting process for accounts receivable.
5. Pursue recovery of Duplicate Primary Payments.
6. Special projects (includes litigation support).

1. **Pursue recovery of identified primary mistaken payments.**

A. **General—Activity Codes 22002, 22003, and 22004**

The response time for all MSP correspondence is 30 days from the date of receipt in the corporate mail room or any other mail center location absent instructions to the contrary for a particular activity.

Acknowledge correspondence when a debtor (or someone on behalf of the debtor) responds to a demand letter in a manner which does not resolve the debt in full (e.g., submits insufficient documentation for an alleged defense, submits only partial payment, submits and inappropriate defense, etc.) These responses should be sent within the time frames given for any normal correspondence or time frames for a specific project if they differ.

B. **Liability, No-Fault, Workers= Compensation – Activity Code 22002**

Contractors are reminded that they must coordinate with the COB contractor to develop further and pursue recovery whenever they receive information that a beneficiary, provider, physician, or other supplier is pursuing a claim against workers compensation insurance, no-fault insurance or liability insurance. In recovery situations, contractors must comply with the lead contractor (if they are not the lead contractor), in all instances, regardless of the amount the non-lead contractor has at issue. There are no development or recovery tolerances in these instances.

Non-Lead contractors must respond to an initial Intercontractor Notice (ICN) request within 30 days and a final ICN request with in 10 days.

Note: *See Attachment for an updated listing of Lead Contractors for each state and designated lead contractors for certain cases.*

HCFA may continue to designate a specific lead contractor for a particular group or class of recoveries (for example, as HCFA has done for certain product liability recoveries) along with allocate additional funding once the workload becomes known.

The responsibility of a lead contractor for Federal Tort Collections Act (FTCA) cases will be to identify Medicare's recovery claim amount and to coordinate/facilitate communications with other

intermediaries and carriers, as required by HCFA CO. For FTCA cases, the lead contractor will be the same as the lead contractor would be for a liability or no-fault case. Please note that although a lead contractor is being designated for FTCA cases, these recoveries will continue to be under the specific direction of HCFA Central Office (CO) staff.

See CR #1163, CR #1558, CR #1244 and CR # 1142

C. **Non-Data Match Group Health Plan – Activity Code 22002**

1) If a group health plan specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make a primary payment, recover the Medicare primary payment from the group health plan or the appropriate party (beneficiary, provider or supplier).

2) In the absence of a known mistaken payment, a contractor is obligated to search history with respect to services to an identified beneficiary for services on or after October 1, 1998. Avenues for identifying potential mistaken payments may come from information on a claim form or through the COB contractor via ECRS. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan's timely filing requirements.

If the history search identifies potential mistaken primary payments that equal or exceed $1000, the contractor is obligated to seek recovery by sending a demand letter to the employer that sponsors or contributes to the group health plan. Contractors must perform history searches at a minimum of 60 days and issuance of the demand letter no later than 30 days after completion of the history search. The recovery demand letter must be issued within 60 days from the date of claim receipt or a trailer update, whichever is earlier." At this time, Contractors are not to recover from the provider, unless the provider has received a duplicate primary payment from the group health plan and Medicare.

Workload Definition -Code 22002

Postpayment Claims—All activities on claims on which you take some MSP action after the initial claims is paid. This includes all adjustment bills, all recoveries from prior improper payments, all retroactive recoveries, and all liability, no-fault and workers compensation cases.

Note: *Appeals are not to be reported as MSP workload. This includes work done to support the appeals staff.*

D. **Recoveries from IRS/SSA/HFCA Data Match – Activity Code 22003**

1) In the absence of a known mistaken payment, a contractor is obligated to search history with respect to services to an identified beneficiary for services on or after October 1, 1998. If the history search identifies potential mistaken primary payments that equal or exceed $1000, the contractor is obligated to seek recovery by sending a demand letter to the employer that sponsors or contributes to the group health plan. Avenues for identifying potential mistaken payments may come from information on a claim form or through the COB contractor via ECRS. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan's timely filing requirements.

2) Send an initial demand letter within 60 days of receipt of a Data Match cycle tape from HCFA or its agent, to the employer. Issuance of the demand letter must be made no later than 30 days after completion of the demand generation. At this time, Contractors are not to recover from the provider, unless the provider has received a duplicate primary payment from the group health plan and Medicare.

The contractor is to update MPARTS within 10 calendar days from completion of evaluation or within 30 calendar days from receipt of information, whichever is less. MPARTS is to be updated with a DS status code prior to the demand being mailed out.

Workload Definition --Code 22003

IRS/SSA/HCFA Data match—All activities on which recovery action was taken as a result of the data match.

2. **Continue Identification of MSP Debt to be Written Off Closed (CR #1280) – Activity Codes 22002, 22003**

See PM AB-01-24

3. Continue the Debt Collection Improvement Act of 1996 (DCIA) process (CR #1538) – Activity Code 22021

See PM AB-01-83

Workload Definition --Code 22021

All activity involved with the DCIA process.

4. Implement the MSP Write-off--Currently Not Collectible (CNC) Identification and Reporting Process for Accounts Receivable – Activity Codes 22002, 22003

Effective 10/1/01 MSP debt should be identified and recommended for write off CNC. Upon RO approval MSP CNC debt are to be tracked on a MC751 report. Standard systems changes are to be released in October 2001. Further instructions will be issued prior to this effective date.

5. Pursue Recoveries of Duplicate Primary Payments – Activity Code 22002

Continue the process of Duplicate Primary Payment (DPP) recoveries this fiscal year. PM instructions will be issued by the end of the fiscal year 2001. This process will not require shared system changes.

The DPP Process will consist of the following:

- National Duplicate Payment Plan Statistics Medicare Overpayment Report file will be sent to the contractors through the Network Data Mover (NDM) process. These reports include summaries of contractor's processed claims that will need to be attached to the duplicate primary payment demand letters, which the contractor will issue. Note: *History searches will not be done within the contractor systems.*
- Issuance of the Demand Letter (PC generated letter).
- Once the demand letters have been sent, the contractor is responsible for updating the online portion of DPP with their recovery and referral efforts.
- Track and report on the HCFA Form M751.

6. Special Projects (Includes Litigation Support) – Activity Codes 22002 - 22006

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

MSP - INQUIRIES - (ACTIVITY CODE 22004)

Include the costs associated with MSP inquiry activities as defined in the workload category below.

Workload Definition --22004

MSP Inquires workload is all activities on which you respond in-person (walk-in), by telephone or by written correspondence concerning MSP issues.

Note: *ECRS entries or phone inquiries that are transferred to the COB contractor that are not claims or case related, but routine and general may be accounted for under Activity Code 22004.*

MSP - OUTREACH - (ACTIVITY CODE 22006)

Include the costs associated with pre-pay and post-pay MSP outreach activities designed to educate attorneys, insurers, beneficiaries and providers as to the Medicare Secondary Payer rules and regulations, processes and initiatives. (CR#1142)

Note: *All outreach materials to be used should have RO approval prior to its use. This is to ensure consistency and accuracy of content.*

Workload Definition --Code 22006

Outreach—All activities related to the outreach efforts undertaken to address the beneficiaries, providers, attorneys and insurers.

Note: *FY 2002, count workload items as you have in the past. We recognize there are differences in how something is counted vs. what is count. (e.g. counting a each piece of correspondence versus one workload count per case)*

A workgroup was formed last year to address consistency in workload reporting. We are in the process of responding to comments on the work groups PM. However due to potential standard systems changes anticipated we do not expect this PM to be released until sometime within FY 2002.

Attachment A

LEAD CONTRACTORS, BY STATE, FOR MSP LIABILITY RECOVERIES
Effective 1/8/01 (revised 5/18/2001, 3/15/2001, 2/27/2001)

NOTE: The list set forth below applies except where HCFA has designated a specific intermediary or carrier as the lead contractor or recoveries for a particular class or group of cases. See the end of this document for a current list of such designations.

Alabama 00010

Cahaba Government Benefit Administrators

MSP Division, PO Box 12647, Birmingham, AL 35202

Alaska 00430

Premera Blue Cross
MSP, PO Box 2847, Seattle, WA 98111-2847

American Samoa 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93101-9140

Arizona 00030

Blue Cross and Blue Shield of Arizona
MSP, PO Box 37700, Phoenix, AZ 85069-7700

Arkansas 00020

Arkansas Blue Cross and Blue Shield
Medicare Services, PO Box 1418, Little Rock, AR 72203

California 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Colorado 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Connecticut 00308

Empire Blue Cross
Empire MSP Services, PO Box 4751, Syracuse, NY 13221-4751

Delaware 00308

Empire Blue Cross and Blue Shield
Empire MSP Services, PO Box 4751, Syracuse, NY 13221-4751

District of Columbia 00190

Care First Blue Cross and Blue Shield of Maryland, Inc.
MSP, 1946 Greenspring Drive, Timonium, MD 21093-4141

Florida 00090

First Coast Service Options, Inc.
MSP, PO Box 44179, Jacksonville, FL 32231

Georgia 00101

Blue Cross Blue Shield of Georgia
MCR Division, PO Box 9048, Columbus, GA 31908-9048

Guam 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Hawaii 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Idaho 00350

Medicare Northwest
MSP, PO Box 8110, Portland , OR 97207-8110

Illinois 00131

Administar Federal
MSP, 225 N. Michigan Avenue, 22nd Floor, Chicago, IL 60681-2912

Iowa 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Kansas 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Kentucky 00160

Administar Federal MSP
9901 Linn Station Road, PO Box 23711, Louisville, KY 40223

Louisiana 00230

Trispan Health Services
MSP, PO Box 23046, Jackson, MS 39225-3046

Maine 00180

Associated Hospital Service of Maine and Massachusetts
MSP, 2 Gannett Drive, South Portland, ME 04106

Maryland 00190

Care First of Maryland, Inc.
MSP, 1946 Greenspring Drive, Timonium, MD 21093-4141

Massachusetts 00180

Associated Hospital Service of Maine and Massachusetts
MSP, 1515 Hancock Street, Quincy, MA 02169-5228

Michigan 00452

United Government Services
MSP, 660 Plaza Drive, 18th Floor, Detroit, MI 48226

Minnesota 00320

Noridian Mutual Insurance Company
MSP, 4305 13th Avenue South, Fargo, ND 58103-3373

Mississippi 00230

Trispan Health Services
MSP, PO Box 23046, Jackson, MS 39225-3046

Missouri 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Montana 00250

Blue Cross and Blue Shield of Montana, Inc.
MSP, PO Box 5017, Great Falls, MT 59403

Nebraska 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Nevada 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

New Hampshire 00270

NH-VT Health Service to Anthem Health Plans of New Hampshire (Anthem of New Hampshire)
MSP, 3000 Goff Falls Road, Manchester, NH 03101

New Jersey 00390

Riverbend
MCR Division/730 Chestnut Street, Chattanooga, TN 37402

New Mexico 00400

TrailBlazer Health Enterprises, LLC
MSP, PO Box 9020, Denison, TX 75021

New York 00308

Empire Blue Cross and Blue Shield
MSP, PO Box 4751, Syracuse, NY 13221-4751

North Carolina 00310

Blue Cross and Blue Shield of North Carolina
MSP, PO Box 3824, Durham, NC 27702

North Dakota 00320

Noridian Mutual Insurance Company
MSP, 4305 13th Avenue South, Fargo ND, 58103-3373

Northern Marianna Islands San Francisco 00454

United Government Services
MSP, PO Box 9140, Oxnard, CA 93031-9140

Ohio 00332

Administar Federal
MCR Division/PO Box 145482, Cincinnati, OH 45250-5482

Oklahoma 00340

Group Health Service of Oklahoma, Inc.
MCR Division/1215 S. Boulder, PO Box 3404, Tulsa, OK 74101

Oregon 00350

Medicare Northwest
MSP, PO Box 8110, Portland, OR 97207-8110

Pennsylvania 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Puerto Rico 57400, 00468

Cooperative de Seguros de Vida de Puerto Rico
MCR Division/PO Box 363428, San Juan, PR 00936-3428

Rhode Island 00370

Blue Cross and Blue Shield of Rhode Island
MCR Division/444 Westminster Street, Providence, RI 02903-3279

South Carolina 00380

Palmetto Government Benefits Administrators, LLC,
MCR Division/PO Box 100190, Columbia, SC 29202

South Dakota 52280

Mutual of Omaha Insurance Company
Medicare, PO Box 1602, Omaha, NE 68101

Tennessee 00390

Riverbend
MCR Division/730 Chestnut Street, Chattanooga, TN 37402

Texas 00400

TrailBlazer Health Enterprises, LLC.
MSP, PO Box 9020, Denison, TX 75021

U.S. Virgin Islands 57400, 00468

Cooperative de Seguros de Vida de Puerto Rico
MCR Division, PO Box 363428, San Juan, PR 00936-3428

Utah 00350

Medicare Northwest
MSP, PO Box 8110, Portland , OR 97207-8110

Vermont 00270

Anthem Health Plans of New Hampshire
MSP, 3000 Goff Falls Road, Manchester, NH 03101

Virginia 00453

United Government Services
MSP, PO Box 12201, Roanoke, VA 24023-2201

Washington 00430

Premera Blue Cross
MSP, PO Box 2847, Seattle WA 98111-2847

West Virginia 00453

United Government Services
MSP, PO Box 12201, Roanoke, VA 24023-2201

Wisconsin 00450

United Government Services
MCR Division/401 N. Michigan, PO Box 2019, Milwaukee, WI 53203

Wyoming 00460

Blue Cross and Blue Shield of Wyoming
MCR Division, 4000 House Avenue, PO Box 908, Cheyenne, WY 82003

LEAD CONTRACTORS, BY STATE, FOR MSP LIABILITY RECOVERIES--Continued

HCFA designated lead contractors for specific groups/classes are recoveries are:

- Gel Implant recoveries: TrailBlazers and Alabama (See attached list for state by state responsibilities)
- Bone Screw recoveries: United Government Services, *United Government Services, MSP, PO Box 9140 Oxnard, CA 93031-9140* (formally known as BCC was originally the lead contractor for AcroMed settlement recoveries; now the lead for all bone screw recoveries.)
- "Diet Drugs" (Fen Phen, etc) recoveries: Cahaba Government Benefit Administrators *MSP Division, PO Box 12647, Birmingham, AL 35202*

Benefit Integrity (Intermediary)

Intermediary budget requests should ensure implementation of all program requirements in the Program Integrity Manual (PIM) and all applicable Program Memorandums (PM). The PIM and applicable PMs should be referenced for instructions relating to the areas specified in this BPR. In addition, each intermediary should provide the supporting documentation requested in Attachment A. Attachment A requests contractor specific narrative, workload, and cost data for FY 2001 and FY 2002.

Contractors must include the following in their budget requests: HCFA training requirements, the Quality Improvement (QI) program, the preparation and submission of program vulnerability reports, and the maintenance of a secure environment.

If the MR unit is asked to do medical review as part of a fraud case development, the MR costs incurred should be charged to the Benefit Integrity (BI) line.

Medicare Fraud Information Specialist (MFIS) (PIM: Chapter 1) (Activity Code 23001):

Report all costs associated with MFIS activity in Activity Code 23001. This activity code applies only to contractors at which the RO has indicated an MFIS will be located. No new MFIS positions will be funded.

Report the number of fraud conferences/meetings coordinated by the MFIS in workload column 1; the number of fraud conferences/meetings attended by the MFIS in workload column 2; and the number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other HCFA health care partners in workload column 3.

Fraud Complaint Development and Other Lead Activities (PIM: Chapter 2) (Activity Code 23002):

Only fraud complaint development costs should be included in this activity (do not include any case development costs in this activity). Once the initial complaint has been closed, if additional costs are incurred to develop a case related to that complaint, those additional costs should be charged to Activity Code 23005.

Report all costs associated with fraud complaint development in Activity Code 23002. Report the number of fraud complaints alleging waste, fraud and abuse referred to the BI unit in workload column 1, the number of fraud complaints closed in workload column 2, and report the number of workload column 2 complaints which resulted in an overpayment collection in workload column 3.

Outreach and Training Activities (PIM: Chapter 1) (Activity Code 23004):

Include costs associated with establishing and maintaining waste, fraud, and abuse outreach and training activities for beneficiaries (excluding MFIS).

Report all costs associated with waste, fraud, and abuse outreach and training activities for contractor staff and beneficiaries in Activity Code 23004. Report the number of training sessions (internal and external) furnished only to BI staff in workload column 1, the number of face-to-face presentations made by BI unit staff to beneficiaries in workload column 2, and the number of training sessions furnished by the contractor BI unit to non-BI contractor staff in workload column 3. Provider education and training activities related to Medicare Integrity Program (MIP) activities can be performed by BI, but costs must be reported on the MIP-PET line.

Note: 1) a training session is the presentation of a topic regardless of the number of attendees; 2) a training session which exceeds more than one day is counted as one session; and 3) the same training session which is repeated at a later date should be counted as a separate session.

Fraud Case Development Activities (PIM: Chapter 1 & 2) (Activity Code 23005):

Report any costs associated with fraud case development and FID entries in Activity Code 23005. Report the number of cases opened in workload column 1. Of the cases reported in workload column 1, report how many were opened by the contractor based on contractor self-initiated proactive data analysis in workload column 2. Report the total number of cases closed (no longer requiring fraud development) and which were not referred to law enforcement in workload column 3.

Law Enforcement Support Activities (PIM: Chapter 1) (Activity Code 23006):

For work done to support law enforcement, report all BI costs and related data analysis costs in Activity Code 23006. Report the total number of law enforcement requests in workload column 1, report the number of requests discussed with the RO in workload column 2, and report the number of BI law enforcement requests that require data analysis in workload column 3.

Medical Review in Support of Benefit Integrity Activities (Activity Code 23007):

Report all costs associated with medical review in support of BI activities in Activity Code 23007. Because the main goal of medical review is to change provider billing behavior through claims review and education, any BI initiated review activity that does not allow for provider education or feedback must also be charged to this activity code. Report the number of cases that the MR unit assisted the BI unit with in workload column 1; the number of claims reviewed by the MR unit for the BI unit in workload column 2, and the number of statistically valid random samples (SVRSs) **performed for overpayment estimation** by MR in support of BI in workload column 3. Report the number of claims medically reviewed by MR and/or BI staff for BI in the Remarks section of the Interim Expenditure Report.

Use of Extrapolation (Miscellaneous Codes 23007/01, 23007/02, and 23007/03)

Contractors must keep a record of only BI work using miscellaneous codes in CAFM II for the following information: the number of consent settlements offered (Miscellaneous Code 23007/01), the number of consent settlements accepted (Miscellaneous Code 23007/02), and the number of SVRSs **performed for overpayment estimation** (Miscellaneous Code 23007/03). Report workload only for the above items.

Attachment A

FY 2002 BENEFIT INTEGRITY (BI) SUPPORTING DOCUMENTATION FOR INTERMEDIARIES

In addition to your CAFM II budget request, HCFA is requesting supporting narrative to justify your FY 2002 budget request. Please provide the information requested below.

Name of Contractor and Contractor Number
Fiscal Year 2002 Budget Request
Narrative and Supporting Justification

I. Staffing/Function Requirements

- Explain the unit cost in Activity Code 23002 (Complaint Development). What functions are charged to this Activity Code?

- What new strategies and functions will you add in FY 2002; what results do you anticipate; and what will be the cost for the functions and strategies?

- Provide new BI staffing requirements in FY 2002 and the functions the staff will perform.

- Explain any significant changes in your staffing mix or FTE level from FY 2001 to FY 2002.

  Note: The total number of FTEs requested in FY 2002 for this activity should equal the number of FTEs which are calculated from productive hours entered into CAFM II.

II. Subcontracts

- Provide the following information for each subcontractor exceeding $25,000 related to this line of your budget request (per Medicare contract, this excludes arrangements you may have with medical consultants to review Medicare claims, health care utilization or related services):

  (1) the name of the subcontractor (please indicate if the subcontractor is another current Medicare contractor or a subsidiary of a Medicare contractor);
  (2) a list of the functions the subcontractor will provide;
  (3) the total cost you expect to incur during FY 2002, for this subcontract;
  (4) if available, the number of FTEs funded by this subcontract.

III. Other

- Include any additional budget narrative that supports your FY 2002 BI funding request.
- Include costs necessary to establish a secure environment as specified in the PIM, Chapter 1, Section 3.2.6.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Audit (Intermediary)

In FY 2002, performance for provider audit and provider reimbursement will be tracked by the Contractor Audit and Settlement Report (CASR), the Provider Reimbursement Profile (PRP), and the Schedule of Providers Serviced (SPS). Fiscal Intermediaries (FIs) must complete the aforementioned reports and submit them to HCFA=s mainframe computer through the CASR system. Instructions for transmission are contained in the CASR User=s Manual.

General Instructions:

- FIs must complete the Budget Request (CASR, PRP, and SPS) in accordance with the instructions contained in HCFA PUBLICATION 13-1, CHAPTER 2, SECTION 1270 to 1274.

- FIs must complete a supporting worksheet showing the details of their calculation for all data shown on the CASR and PRP. FIs are to use available time records to support the hours indicated. These data can be extracted from the STAR system, if necessary. The supporting worksheets are to be maintained in the FI=s files for review or submission to HCFA at a later date.

- Each FI=s budget is to furnish sufficient funding to complete all required desk reviews, audits, and settlements.

- Audit Quality - FIs must continuously strive to comply with all audit standards and instructions, especially those regarding audit techniques, implementation of adjustments, and the expansion of audits based on preliminary findings and managerial review. Each audit must address the issues identified for field review by properly performing all necessary audit steps and procedures, and documenting them in properly prepared and supervisory reviewed audit working papers.

- For FIs that are involved in the special audit effort of 301 providers, they must plan to attain the completion of the reviews by September 30, 2002. Since these are all full scope audits and are for a special purpose, they must adhere to the highest audit quality standards.

- Auditor Training- In accordance with the program memorandum (Change Request #1468) and HCFA Pub. 13-4, FIs are required to ensure that their audit staffs receive training and meet Continuing Education Standards. We suggest that the FI staff, including supervisors, receive training in Medicare Principles of Reimbursement, work paper preparation, documentation of audits, and how to perform supervisory reviews. During FY 2002 FIs are to ensure that these standards are met.

- HCFA has made it a priority to concentrate its audit efforts on reimbursement areas that it considers to be high risk. For hospitals and HHAs, the Medicare contractor should concentrate audits to areas where inappropriate cost shifting could occur. Specific attention should be given to any provider/consultant prepared reserve cost reports, bad debts, organ procurement costs, indirect and direct medical education, disproportionate share, allocations between providers, and subproviders, and areas of cost reimbursement in the HHAs.

- In major teaching Hospitals, the contractor must concentrate on Disproportionate Share, Graduate Medical Education, Indirect Medical Education, excluded units and outpatient costs.

- In accordance with guidance provided in the HCFA Program Memorandum (Change request #1468), all FIs are to achieve currency in settlement of all provider cost reports within 24-30 months from the beginning of FY 2002. This means that by mid FY 2004 all FIs should be current in settlements.

- HCFA has identified the following workload goals based on an internal risk assessment and priorities established by recent legislation. These percentages may be modified if other priorities arise that supercede these goals. The following represents the national audit level targets for the given categories.

Provider Type	Level of Audit including Focused Reviews
End Stage Renal Dialysis Audits (FY 2002 audits for free standing providers with FYEs in 2000)	33.3 %
Home Health Agency Audits--Remaining cost reimbursed Free Standing Facilities	12.5%
Hospital Multi-Facility PPS (Priority goes to facilities with an HHA subprovider and large Teaching Hospitals)	20.0%
Hospital single facility	25.0%
Hospital multi-facility --Non PPS	25.0%
Chain Home Offices	30.0%
Certified Mental Health Center (CMHCs)	50.0%
Skilled Nursing Facilities (SNFs)--Over 10 % Medicare Utilization & over $300,000 in reimbursement	0.0%
Other--including Rural Health Clinics(RHCs), Outpatient Physical Therapy OPTs, Comprehensive Outpatient Rehabilitation Facilities CORFs, and Hospices	10% or less

NOTE: WHILE IT IS ANTICIPATED THAT THESE PERCENTAGES WILL BE ATTAINED NATIONALLY, RO'S AND FI'S WILL NEGOTIATE BUDGETS BASED UPON EACH FI=S PROVIDER MIX AND OTHER AUDIT SELECTION FACTORS. ALSO, HCFA'S SPECIAL AUDIT INITIATIVE MAY IMPACT ON THE FI'S ABILITY TO REACH THESE GOALS. THE ROs SHOULD CONSULT WITH THE HCFA CENTRAL OFFICE PRIOR TO ANY FINALIZATION OF INTERMEDIARY BUDGETS.

Provider Audit Budget Development - General Guidelines (Activity Codes 26001, 26002, 26003)

FIs should attempt to optimize the audit budgets by ascertaining risk, in conjunction with the HCFA stated goals, and utilizing focused audits wherever possible. This will allow FIs to optimize the funding available and impact more at risk program dollars. FIs should continue to expand their use of limited desk review procedures.

The selection of providers to be reviewed/audited should be sensitive to the amount of Medicare payments at risk, new providers, etc. As discussed below, it is essential to perform Acyclical≅ reviews of those providers whose cost reports will not be subject to a full desk review. This cyclical effort is necessary to maintain the sentinel effect of the audit process. The examinations may be performed as an audit or focused review.

Each Contractor should consider the following risk profiles when selecting providers for review/audit, in addition to the National Goals:

- Hospitals with organ procurement costs of $500,000 or more. HCFA agreed to prioritize the audit of these facilities in response to findings issued by Office of the Inspector General.

- Hospitals whose Medicare reimbursement is $15 million or more. Concentrate on the largest teaching hospitals and multi-facility hospitals. Special attention should be given to those facilities where inappropriate cost shifting to subproviders or provider based units could occur. In addition, special emphasis must be placed on the audit of the Medicaid days for the DSH adjustment to insure that the program is paying properly for this passthrough cost. You should also place special emphasis on the intern and resident counts for GME, and make this area a highly focused area for all teaching hospital audits. Additionally, you are to focus your audit on the claimed observation bed days to insure that the provider has counted those days in accordance with regulations and program instructions.

  Those hospitals with hospital based HHAs should be given priority and the fiscal intermediaries should give special attention to those hospitals that have management contracts for the administration of their HHAs. The FI should concentrate on reviewing the management contracts and comparing the services rendered by the management contract to the HHA with the costs allocated to the HHA from the hospital to insure that there is no duplication of payment for costs claimed twice. In addition, the FIs must look to insure that the proper allocation of overhead to the HHA is occurring and that the HHA actually utilizes the cost that is being stepped down to it. For those hospitals with Hospital Based SNFs, the FI should insure the proper allocation of costs from the hospital to the SNF. In addition, the FI should insure that the allocation of costs in the SNF between distinct part and non-distinct part is properly shown. As part of your review of the provider, you are to inquire as to whether or not the provider maintains a reserve cost report, and you are to request the reserve report if they state that one is being maintained.

- Freestanding Home Health Agencies whose Medicare reimbursement is $1 million or more and Medicare utilization is at least 55 percent. The FI is to look at the liquidation of liabilities to insure (1) that the provider has liquidated those liabilities timely in accordance with regulations and manual instructions, and (2) that the accruals that were made at the end of the year were proper. In addition the FI is to insure that when the accruals were liquidated that the provider did not claim those costs again as an expense. The FI is to insure that if there is a management contract that there is no duplication of costs with those services provided by provider personnel. In addition, if the provider is receiving an allocation of overhead from a related hospital, the FI is to insure that the costs allocated are proper, and are not duplicative of those costs incurred by the HHA in the performance of their operations. The FI is to insure that all costs incurred between related organizations are reflected on the cost reports of the HHAs as the cost to the related organization and not the charge incurred from the related organization. When accomplishing this goal the FIs are to ascertain the necessity of auditing based on the amount of cost that is still subject to cost reimbursement in the universe of providers the FI has.

- Skilled Nursing Facilities, we do not anticipate performing any audits of facilities that are covered by the SNFPPS**.** However, for any providers that are still open for pre-PPS years the FIs should give them priority. Focus those audits on SNFs that have subproviders, respiratory therapy services, and the allocation of cost between Certified and Non-certified areas to ensure the provider has the proper documentation to properly reflect the separation of costs. If the documentation does not exist the areas are to be collapsed into one unit. **NOTE, HCFA does not have a zero tolerance policy in this area so the FIs must ensure that any collapse to a per diem is fully justified and supported in your working papers.**

- Give Priority to Chain Home Office audits for those chains that have significant cost reimbursement or can shift costs through more sophisticated allocation methods. Focus the audits toward those chains with more cost based units and large Home Health Agency and Skilled Nursing Facility Chains where there are franchises. The FIs are to insure that the chains are properly allocating costs to the providers in the chain in a manner approved by HCFA. Determine that you are able to account for all related organizations and ask for a letter of representation that the home office has disclosed all organizations that are related to it. In addition, the FI is to review the due to and due from accounts on the home office trial balance to insure that the home office has not directly assigned cost to providers in an improper manner.

- Community Mental Health Clinics are to be audited to insure that all costs claimed are reasonable and necessary and are related to patient care and that the statistics used to allocate and apportion cost are appropriate and accurate.

- End Stage Renal Disease Facilities are to be audited in accordance with BBA requirements. The FIs are to insure that one third of all fiscal year 2000 ESRD facilities are reviewed in FY 2002. The following criteria are to be used--the facilities are over the composite rate and render large numbers of treatments. Supplemental instructions to the audit instructions already issued concerning audit and desk review procedures have been issued.

- Rural Health Clinics that share offices with Physician Offices are to be audited to insure that the proper costs are allocated to the Medicare cost report and that these reports are not charging the program for costs that are not program related.

- Any Audit Initiatives that the contractor or the regional offices believe should be included that differ from the National Targets or above profiles, must be explained in detail.

The number of field audit hours required for PPS Hospitals, TEFRA Hospitals, SNFs, HHAs, and other providers should reflect the estimated time necessary to complete an audit in accordance with HCFA=s guidance regarding the implementation of Government Auditing Standards.

Audit supervisors and staff are required to receive 80 hours of training every 2 years in order to comply with the revised Government Auditing Standards, which were effective January 1, 1989.

FIs are no longer required to comply with the TEFRA and PPS audit review guidelines contained in Sections 4117 and 4118 of HCFA PUB-13-4, Medicare Intermediary Manual. These guidelines will be removed from the manual. FIs should identify and settle all reopened cost reports for which additional information is not required; e.g., providers with home office adjustments, requests from providers, reopenings from appeals decisions, etc. Reopenings should be initiated where appropriate in accordance with HCFA instructions. FIs **must** insure that all provider cost reports which still require Home Office Cost Statement finalization have been reopened in accordance with program requirements.

Field audits must include the review of a provider=s documentation to support the Form HCFA-838, Medicare Credit Balance Report. The applicable hours to complete credit balance reviews are to be included in the total number of hours needed to perform an audit.

Supporting Documentation

Contractors are to submit the requested information in Attachment A (file 2002faud.xls).

This information should be as accurate as possible, but can be estimated based on the prior year's audit experience.

Workload

Desk Reviews (Activity Code 26001)

Include in line 2a of the CASR IER (CIER) the total number of units (cost reports) when the desk reviews are completed. The total number of units (line 2a) is the total of lines 3a (limited desk reviews) and 4a (full desk reviews). This count (line 2a) is the same as, and should be reported as workload 1 in CAFM II (HCFA-Activity Code 26001) and does not include any count for provider-based facilities.

Field Audits (Activity Code 26002)

Include in line 6b of the CASR IER (CIER) the total count for all audit types-line 7b (focused audit) and line 8b (field audit)- for procedures performed on a cost report. An audit includes all work efforts subsequent to the completion of the desk review up to, but not including, the reworking of the cost report. The units shown in line 6b should be reported as Workload 1 in the CAFM II (Activity Code 26002).

Settlements (Activity Code 26003)

Include in line 10a of the CASR IER (CIER) the number of cost reports settled. A cost report is settled when the NPR is mailed or transmitted. This should be reported as Workload 1 in CAFM II (HCFA Activity Code 26003). Settlements include work performed on a cost report after the completion of the desk review, or audit, and after the final exit conference.

NOTE: Problem Resolution is now considered part of the desk review process.

FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Provider Education and Training (Intermediary)

Intermediary budget requests should ensure implementation of all program requirements in the Program Integrity Manual (PIM) and all applicable Program Memoranda (PM). The PIM and applicable PMs should be referenced for instructions relating to the areas specified in this Budget and Performance Requirements (BPRs).

The FY 2002 MIP-PET BPRs concentrate on educational activities that provide feedback to assist all providers in the detection and avoidance of waste, fraud and abuse. It promotes education as a critical aspect in progressive corrective action (PCA) to resolve problems identified through medical review (MR) and emphasizes the use of data analysis to focus other provider education and training activities. Also, emphasize provider enrollment activities when aberrant conditions are recognized during the enrollment of providers.

Costs associated with MIP-PET work products and activities should be charged to Activity Code 24001. This includes MIP-PET activities performed by the MR, benefit integrity and provider enrollment areas. This code should not be charged for any PM-PET activities. Since provider education is such an integral part of MR, refer to the MR BPRs for clarification on specific MR or PCA education activities.

MIP-PET ACTIVITIES (Activity Code 24001)

- Identify costs of providing one-on-one feedback to individual providers on specific problems identified through prepay and postpay medical review. Use PCA in focusing your educational activities.

- Identify costs of providing feedback to the larger provider community on widespread errors. Use data analysis and MR results to direct these educational activities.

- Identify costs associated with providing general fraud and abuse information about program integrity activities. This includes sharing information on program integrity goals and processes with local medical societies, professional associations, and other specialty provider organizations in order to reach as many providers as possible.

- Identify costs associated with production of newsletters, bulletins, and websites containing program integrity information for providers. Unless specifically requested by the provider, eliminate regular bulletins sent to providers with no billing activity in the past twelve months. Bulletins should be posted on contractor websites where providers may obtain extra copies.

- Promote interaction and coordination among the intermediary's fraud unit, MR unit, provider enrollment unit, and provider relations unit. This interaction and coordination is essential in determining the appropriate training to perform to resolve program integrity issues.

- Assure prompt, accurate, and courteous replies to all incoming calls and letters requesting educational information, clarifications, etc.

OPTIONAL MIP-PET ACTIVITIES (Activity Code 24001)

Identify costs associated with these optional activities:

- Provide remedial education to Administrative Law Judges (ALJs) and MIP-related policies and administrative procedures.

- Prepare/distribute computer based training modules, videos, and other materials that address MIP issues.

ALLOCATION OF INTERMEDIARY COSTS TO MIP-PET

Regarding any general seminars, conventions, or conferences which address fraud and abuse as well as issues outside of the fraud and abuse area, the proportional share of the cost of a function to be allocated to MIP-PET is equal to the percentage of time related to addressing fraud and abuse issues times the cost of the function.

Regarding any bulletins, letters, inserts, videos, teleconferences, or educational materials which contain fraud and abuse issues as well as issues outside of the fraud and abuse area, the proportional share of the cost of any of these items to be allocated to MIP-PET is equal to the percentage of the medium related to addressing fraud and abuse issues times the cost of the letter, insert, video, telephone lines, or educational material (e.g., if it costs $4,000 to produce and distribute a bulletin, containing 25 percent fraud and abuse information, to 5,000 providers, then the MIP-PET cost would be equal to $4,000 times .25 or $1,000). The PM-PET cost would be the remaining $3,000.